ATTACHMENT 8 Sample CMS 1500 claim form for HealthCheck nursing agency

(Follow-up visit and lab handling fee)

PICA		IEALTH INS				RM		PICA		
1. MEDICARE MEDICAID CHAMPUS CH		CA OTHER KLUNG	1a. INSURED'S	I.D. NUMBE	₹	((FOR PR	OGRAM IN ITEM 1)		
	A File #) (SSN or ID)	(SSN or ID) (SSN) (ID)			1234567890					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE	3. PATIENT'S BIRTH DATE SEX			4. INSURED'S NAME (Last Name, First Name, Middle Initial)					
Recipient, Im A.	02 10 03 M	FΧ								
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP T	O INSURED	7. INSURED'S	ADDRESS (N	o., Street))				
609 Willow St	Self Spouse Child	d Other								
	TATE 8. PATIENT STATUS	<u> </u>	CITY					STATE		
Anytown		¬						SIAIE		
ZIP CODE TELEPHONE (Include Area Code		Other								
ZIF CODE TELEFHONE (Include Area Code	Employed Full-Time	Part-Time	ZIP CODE		TEL	EPHONI	E (INCLU	IDE AREA CODE)		
55555 (XXX) XXX-XXX	Student	Student				()			
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initia	10. IS PATIENT'S CONDITION	N RELATED TO:	11. INSURED'S	POLICY GRO	OUP OR F	FECA NU	JMBER			
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT	OR PREVIOUS)	a. INSURED'S I	DATE OF BIR	ŢН			SEX		
	YES	YES NO		DD Y	r	М		F		
OTHER INSURED'S DATE OF BIRTH SEX	b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S	S NAME OR S	CHOOL	NAME	<u> </u>			
MM DD YY	☐ YES ☐	□NO i i		0110	. J. 100L			•		
EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT?		- 1001:20:00=	DI 441	00.555	004::				
. I I I I I I I I I I I I I I I I I I I		¬o	c. INSURANCE	PLAN NAME	UH PRO	GHAM N	IAME			
W0.10 100 D		YES NO								
INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL	USE	d. IS THERE AN	NOTHER HEA	ER HEALTH BENEFIT PLAN?					
		·	YES	☐ NO	If yes,	, return to	and cor	mplete item 9 a-d.		
READ BACK OF FORM BEFORE COMP 2. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE Lauthor	ETING & SIGNING THIS FORM.	formation account	13. INSURED'S	OR AUTHOR	IZED PEI	RSON'S	SIGNAT	URE I authorize		
to process this claim. I also request payment of government benefit			payment of r	medical benef scribed below.	its to the u	undersigi	ned phys	ician or supplier for		
below.	, , , , , , , , , , , , , , , , , , , ,	,	30111003 003	cibea below.						
SIGNEDDATE			CICNED							
		001411 40 11 1 1500	SIGNED 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION							
MM DD YY INJURY (Accident) OR	15. IF PATIENT HAS HAD SAME OF GIVE FIRST DATE MM DE	SIMILAR ILLNESS.	I MM	TENT UNABL DD Y	E TO WO		MM i	OCCUPATION DD YY		
PREGNANCY(LMP)			FROM			то	- !			
7. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING	PHYSICIAN	18. HOSPITALIZ	ZATION DATE ; DD ; Y		TED TO	CURREN MM ;	IT SERVICES DD YY		
			FROM		•	TO				
9. RESERVED FOR LOCAL USE			20. OUTSIDE LA	AB?		\$ CHAF	RGES	•		
			YES	NO	I		- 1			
1. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE	EMS 1,2,3 OR 4 TO ITEM 24E BY LINE	E) —	22. MEDICAID F	RESUBMISSION	DN OC					
_{1. L} V20.2		· •	CODE		I ORIG	SINAL RE	EF. NO.			
1. [120:2	3	'	23. PRIOR AUTI	HORIZATION	NUMBER	-				
			20.11110117011	HOHIZAHON	NONBEL	1				
2	4	, _								
4. A B C DATE(S) OF SERVICE Place Type PRO	D CEDURES, SERVICES, OR SUPPLIES	E	F	G DAYS	H S EPSDT	-	J	. к		
From To of of	(Explain Unusual Circumstances)	DIAGNOSIS CODE	\$ CHARGE	e OR	Family	EMG	сов	RESERVED FOR LOCAL USE		
MM DD YY MM DD YY Service Service CP	HCPCS MODIFIER	- 322	<u> </u>	UNIT	S Plan					
2 17 03 11 9	9211 EP	1	XX	XX 1.0)					
2 17 03 11 9	9000		Х	XX 1.0)					
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5. FEDERAL TAX I.D. NUMBER SSN EIN 26, PATIE	NT'S ACCOUNT NO. 27, ACCEP	T ASSIGNMENT?	OR TOTAL OLIV		20. 4::5	INIT SA	_	0.0414400		
	(For gov	rt. ciaims, see back)	28. TOTAL CHAP		29. AMOL	UNI PAII		0. BALANCE DUE		
	4JED YES	□ NO		XX XX	\$	i		s XXX XX		
	AND ADDRESS OF FACILITY WHERE RED (If other than home or office)	SERVICES WERE	33. PHYSICIAN'S & PHONE #	S, SUPPLIER	'S BILLIN	G NAME	, ADDRE	SS, ZIP CODE		
INCLUDING DEGREES OR CREDENTIALS RENE	(I certify that the statements on the reverse			lina						
(I certify that the statements on the reverse	apply to this bill and are made a part thereof.)			I.M. Billing						
(I certify that the statements on the reverse				_						
(I certify that the statements on the reverse apply to this bill and are made a part thereof.)			1 W. Wi	illiams						
(I certify that the statements on the reverse				illiams		55 GRP#		87654321		